

Nebraska
Center
for
Rural
Health
Research

The Cost of Uncompensated Health Care and the Expenditures of Self-Pay Hospital Inpatient Care in Nebraska

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The Nebraska Center for Rural Health Research, formed in 1990, is organized as a multicampus center located within the Department of Preventive and Societal Medicine, University of Nebraska Medical Center.

The broad mission of the Center is to conduct research and analysis related to improving health care delivery in rural areas. The Center focuses on special populations among rural residents, including the elderly, children, minorities, mentally ill, underinsured and uninsured, and new immigrants whose needs for assistance are unique. Members of our Center work collaboratively with the Rural Policy Research Institute (www.rupri.org).

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Executive Summary

Data are presented reflecting the payment for health care by means other than insurance, the dollar value of charity care reported by Nebraska health care providers, and the estimated dollar value of differences between payment from public insurance plans (Medicare and Medicaid) and the revenue otherwise expected. We present data from various types of providers most likely to treat the uninsured (hospitals, rural health clinics, federally qualified health centers), and for regions of Nebraska. Recognizing the limitations of the data, especially when considering sub-state differences and trends, and potential multiple explanations for differences detected, we do not offer definitive interpretations of the data presented in this report. Our intent is to contribute to the ongoing public dialogue in Nebraska and elsewhere regarding the broader implications of an uninsured population by presenting the best estimates of burdens created for health care providers, using accessible data.

Cost of Uncompensated Health Care in Nebraska

- The estimated expenses associated with the uncompensated care (i.e., the combination of traditional charity care and bad debt) provided by all 94 hospitals in Nebraska were \$256.8 million (i.e., \$256,828,760) in 2003.
- The estimated Medicaid payment shortfalls for all 94 hospitals in Nebraska were \$127.7 million (i.e., \$127,669,053) in 2003.
- The estimated Medicare payment shortfalls for all 94 hospitals in Nebraska were \$266.1 million (i.e., \$266,061,255) in 2003.
- The estimated total expenses of the uncompensated care (i.e., the combination of traditional charity care and bad debt) provided by all 106 certified rural health clinics in Nebraska were \$2.5 million (i.e., \$2,530,856) in 2003.
- Uncompensated care accounted for an estimated 6.4% of the total expenses of rural health clinics in Nebraska in 2003.
- The total discounts provided to self-pay patients due to charity care in Nebraska's five federally qualified health centers in 2003 were \$3.3 million (i.e., \$3,260,089).

Expenditures for Hospital Inpatient Care Utilization of Self-Pay Patients

- In Nebraska, the estimated total expenses for hospital inpatient care of self-pay patients increased by 92% from \$13.7 million in 1996 to \$26.2 million in 2003.
- Every resident in Nebraska, on average, bore a cost of almost \$15 due to hospitals' inpatient care for self-pay patients in 2003, which was an 80% increase from the per resident cost of \$8.3 in 1996.

- Residents in the Central Health Planning Region (i.e., Health Planning Region 3 or HPR 3) of Nebraska had the greatest per resident estimated expenses for hospital self-pay inpatient care in 2001-2003, as compared to their counterparts in the other five regions of the state.
- Residents living in the western part of the state (i.e., Western, Southwestern, and Central Health Planning Regions) incurred a statistically significantly higher per resident charge for hospital inpatient care of self-pay patients than did residents living in the eastern part of the state (i.e., eastern, southeastern, and northern regions).
- Nebraska counties with a higher unemployment rate, a lower per capita income, and a greater percentage of population under Temporary Assistance for Needy Families (TANF) assistance incurred a statistically significantly higher per resident charge for hospital inpatient care of self-pay patients than did their counterpart counties.

Background

The number of uninsured people in America increased from 40.0 million in 1999 to 44.7 million in 2003 (PricewaterhouseCoopers, 2005). This increase has imposed a significant financial burden on a variety of safety net providers such as community hospitals, rural health clinics, and federally qualified health centers. For instance, the uninsured accounted for 38% of outpatient visits and 23% of inpatient admissions in American safety net hospitals in 2002 (Regenstein & Huang, 2005).¹ In Nebraska, the percentage of all residents without any health insurance increased from 8.6% in 1996 to 11.6% in 2003.² With a growing uninsured population, safety net providers in Nebraska have also been bearing a significant financial burden of caring for the uninsured and underinsured. To have a better understanding of the financial burden of Nebraska safety net providers, in this report we quantified the financial magnitude of uncompensated health care provided by three major types of safety net providers—hospitals, rural health clinics, and federally qualified health centers (*Section I*). In addition, we analyzed hospital self-pay inpatient discharge data to examine the time trend (i.e., 1996-2003) and geographic variation (among six health planning regions) in hospital inpatient care utilization by self-pay patients (*Section II*). Moreover, to better understand the potential reasons for the use of uncompensated care, we used statistical modeling to examine the economic and geographic determinants of hospital inpatient expenditures by self-pay patients (*Section III*).

Purpose and Limitations

This report is intended to inform public dialogue regarding the burden to the health care delivery system created by a proportion of the population being without any health insurance. General data are used to indicate the *possibility* of financial problems; we do not have access to data to link specific instances of financial difficulty to the dollar value of lost revenue due to uncompensated care. However, the measures we report are reasonable estimates of financial consequences of an uninsured population; they are *proxy* measures for more precise estimates of impact on ability to afford providing services. Sub-state analyses are presented using survey data for the uninsured population, which are estimates based on small samples and subject to annual fluctuation that may not be due to actual changes in the actual numbers. However, the underlying trend analysis is more dependable because several years are included, which helps smooth the trend analysis.

I. Cost of Uncompensated Health Care in Nebraska

A. Hospitals

1. *Traditional Charity Care and Bad Debt Expenses*

The estimated expenses associated with the uncompensated care (i.e., the combination of traditional charity care and bad debt) provided by all 94 hospitals in Nebraska were \$256.8

¹ Regenstein and Huang (2005) define safety net hospitals as “a subset of public and not-for-profit hospitals that provides disproportionate amounts of care to low-income and uninsured patients”.

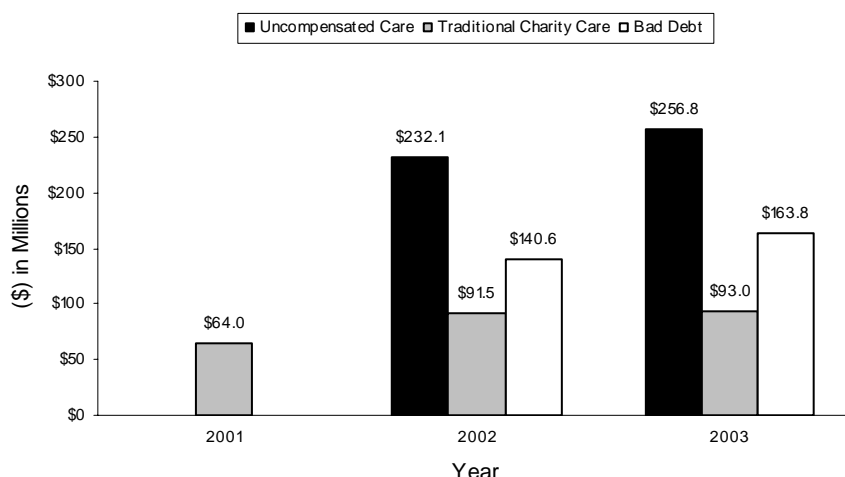
² These estimates are from the annual Behavioral Risk Factor Surveillance System. The 95% confidence intervals for 1996 point estimate were (7.2%, 10.0%) and for 2003 point estimate were (10.4%, 12.8%).

million (i.e., \$256,828,760) in 2003, which was a 10.7% increase from the estimated expenses of \$232.1 million (i.e., \$232,098,963) in 2002 (Figure 1).

The estimated expenses associated with the traditional charity care provided by all 94 hospitals in Nebraska were \$93 million (i.e., \$92,998,922) in 2003, which was a 1.7% increase from the estimated expenses of \$91.5 million (i.e., \$91,468,938) in 2002 and a 45% increase from the estimated expenses of \$64.0 million (i.e., \$63,972,437) in 2001 (Figure 1).

The estimated bad debt expenses associated with all 94 hospitals in Nebraska were \$163.8 million (i.e., \$163,829,838) in 2003, which was a 16.5% increase from the estimated expenses of \$140.6 million (i.e., \$140,630,025) in 2002 (Figure 1).

Figure 1. Estimated Expenses of the Uncompensated Care, Traditional Charity Care, and Bad Debt Write-offs Provided by Nebraska Hospitals, 2001-2003



Sources: Nebraska Hospitals Community Benefits Reports 2003 and 2004, Nebraska Hospital Association; and American Hospital Association (AHA) Annual Survey Database, 2001-2003.

Note: (1) Bad debt data were not available for the year 2001.

(2) Hospital community benefit survey data for a sample of hospitals (sample size varies by year) from the Nebraska Hospital Association and service volume data (i.e., adjusted patient days) for all 94 hospitals from the AHA survey database were used to estimate the statewide hospital charity care and bad debt expenses. See Data Notes section for the estimation methodology.

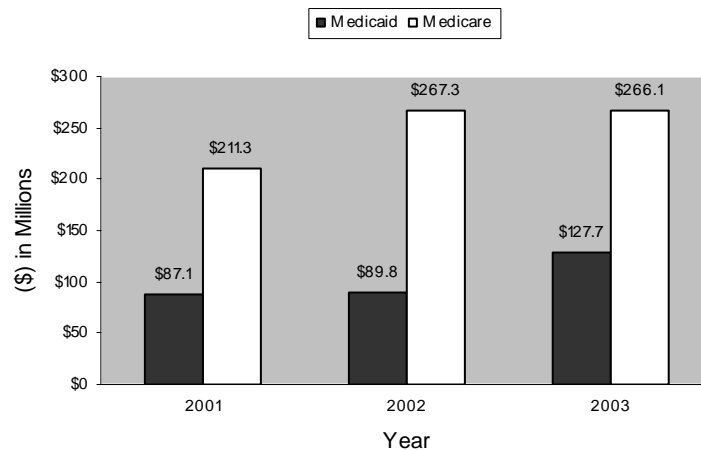
(3) The expense of uncompensated care is defined as the combination of traditional charity care and bad debt expenses.

2. *Medicaid and Medicare Payment Shortfalls*

The estimated Medicaid payment shortfalls for all 94 hospitals in Nebraska were \$127.7 million (i.e., \$127,669,053) in 2003, which was a 42.1% increase from the estimated payment shortfalls of \$89.8 million (i.e., \$89,821,966) in 2002 and a 46.5% increase from the estimated payment shortfalls of \$87.1 million (i.e., \$87,133,908) in 2001 (Figure 2).

The estimated Medicare payment shortfalls for all 94 hospitals in Nebraska were \$266.1 million (i.e., \$266,061,255) in 2003, which was a 0.5% decrease from the estimated payment shortfalls of \$267.3 million (i.e., \$267,285,401) in 2002 and a 25.9% increase from the estimated payment shortfalls of \$211.3 million (i.e., \$211,284,044) in 2001 (Figure 2).

Figure 2. Estimated Payment Shortfalls from Medicaid and Medicare Programs in Nebraska Hospitals, 2001-2003



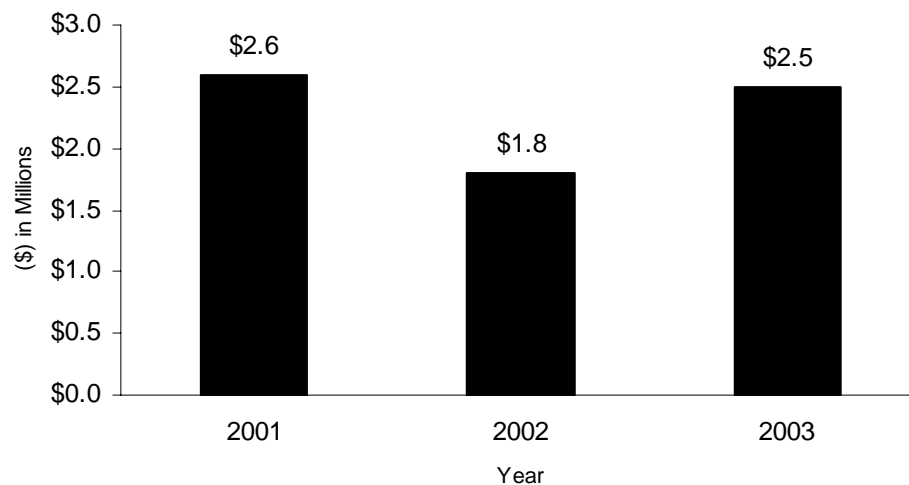
Sources: Nebraska Hospitals Community Benefits Reports 2003 and 2004, Nebraska Hospital Association; and American Hospital Association (AHA) Annual Survey Database, 2001-2003.

Note: Hospital community benefit survey data for a sample of hospitals (sample size varies by year) from Nebraska Hospital Association and service volume data (i.e., Medicaid and Medicare patient days) for all 94 hospitals from the AHA survey database were used to estimate the statewide hospital payment shortfalls from Medicaid and Medicare programs. See Data Notes section for the estimation methodology.

B. Rural Health Clinics

The estimated total expenses of the uncompensated care (i.e., the combination of traditional charity care and bad debt) provided by all 106 certified rural health clinics in Nebraska were \$2.5 million (i.e., \$2,530,856) in 2003, which was a 38% increase from the estimated total expenses of \$1.8 million (i.e., \$1,828,076) in 2002 and a 4% decrease from the estimated total expenses of \$2.6 million (i.e., \$2,645,972) in 2001.³ (Figure 3)

Figure 3. Estimated Total Expenses of the Uncompensated Care Provided by Rural Health Clinics in Nebraska, 2001-2003



Source: 2005 Rural Health Clinic Uncompensated Care Survey, Nebraska Center for Rural Health Research.

Note: The expense of uncompensated care is defined as the combination of traditional charity care and bad debt expenses.

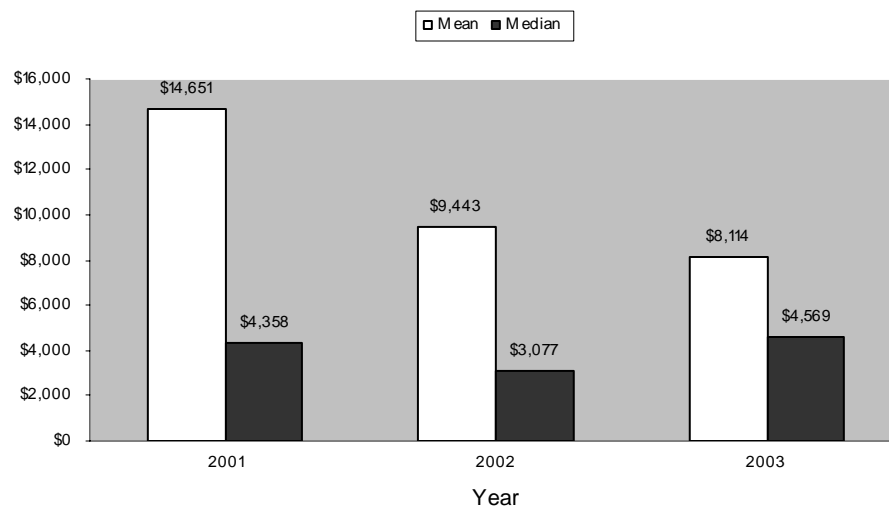
³ The per clinic estimate of uncompensated care expenses was obtained by summing the year-specific median values of the traditional charity care and bad debt expenses from the sample of responding clinics in our survey.

1. *Traditional Charity Care Expenses*

The median expense⁴ of the traditional charity care provided by the 26 rural health clinics in Nebraska that responded to the survey was \$4,569 per clinic in 2003, which was a 48% increase from the median expense of \$3,077 per clinic in 2002 and a 5% increase from the median expense of \$4,358 in 2001 (Figure 4).

The estimated total expenses of the traditional charity care provided by all 106 certified rural health clinics in Nebraska were \$0.5 million (i.e., \$484,314) in 2003, calculated using the median value of the 26 responding clinics in our survey⁵ [i.e., (\$4,569 per clinic) x (106 clinics)].

Figure 4. Mean and Median Expenses of the Traditional Charity Care Provided by 26 Rural Health Clinics in Nebraska That Responded to the Survey, 2001-2003



Source: 2005 Rural Health Clinic Uncompensated Care Survey, Nebraska Center for Rural Health Research.

Note: The mean and median values were based on the sample of the 26 responding clinics that provided complete 2001-2003 charity care information in the survey.

⁴ Although both mean and median values are presented in the figures, the median values may be more reliable because of the small sample size. The mean values may be easily distorted by a few outliers within the sample.

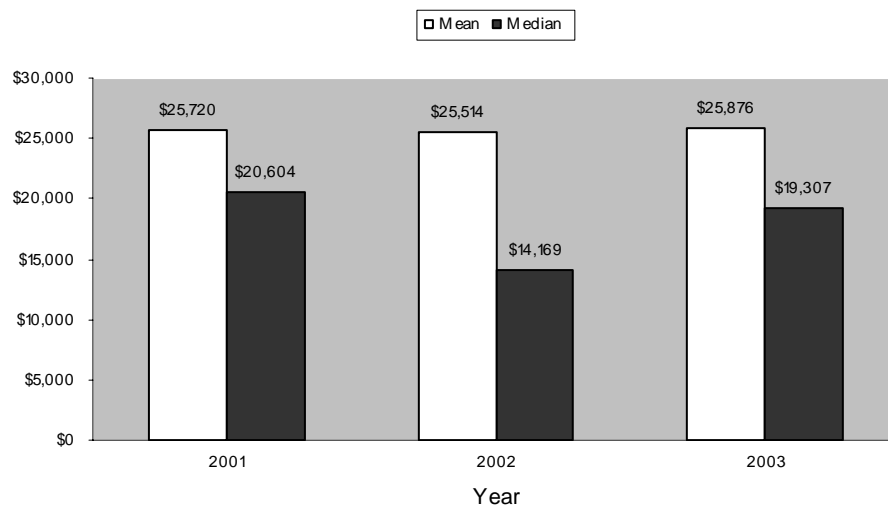
⁵ Among the responding clinics in our survey, only 26 provided complete information on charity care for 2001-2003.

2. *Bad Debt Expenses*

The median expense of bad debt in 31 rural health clinics in Nebraska that responded to the survey was \$19,307 per clinic in 2003, which was a 36% increase from the median expense of \$14,169 per clinic in 2002, while the median value in 2001 was the highest among the three years (i.e., \$20,604 per clinic) (Figure 5).

The total estimated expenses associated with the bad debt write-offs of all 106 certified rural health clinics in Nebraska were \$2.0 million (i.e., \$2,046,542) in 2003, calculated using the median value of the 31 responding clinics in our survey⁶ [i.e., (\$19,307 per clinic) x (106 clinics)].

Figure 5. Mean and Median Expenses of Bad Debt Write-offs in 31 Rural Health Clinics in Nebraska That Responded to the Survey, 2001-2003



Source: 2005 Rural Health Clinic Uncompensated Care Survey, Nebraska Center for Rural Health Research.

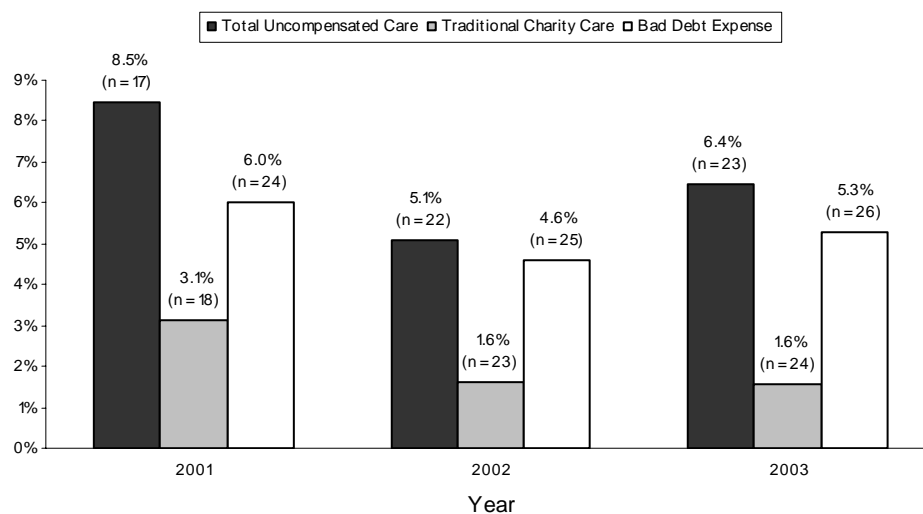
Note: The mean and median values were based on the sample of the 31 responding clinics that provided 2001-2003 bad debt information in the survey.

⁶ Among the responding clinics in our survey, only 31 clinics provided complete information on bad debt expenses for 2001-2003.

3. *Uncompensated Care as a Percentage of Total Clinic Expenses*

Although fluctuating over years, uncompensated care was estimated to account for 6.4% of total rural health clinic expenses in 2003. If the expenses were broken down, bad debt and traditional charity care accounted for 5.3% and 1.6% of total rural health clinic expenses in 2003, respectively (Figure 6).

Figure 6. Estimated Uncompensated Care, Traditional Charity Care, and Bad Debt as Percentages of Total Expenses in Rural Health Clinics in Nebraska, 2001-2003



Source: 2005 Rural Health Clinic Uncompensated Care Survey, Nebraska Center for Rural Health Research.

Note: The percentages were based on responding samples. The sample size of responding clinics varies by year and by variable of interest. Therefore, the percentages of uncompensated care may not equal the sum of percentages of traditional charity care and bad debt.

C. **Community Health Centers**

The total discounts provided to self-pay patients due to charity care in the five federally qualified health centers (FQHCs) in Nebraska in 2003 were \$3,260,089. The total expenses associated with the bad debt write-offs for self-pay patients in four of the five Nebraska FQHCs were \$658,871 in 2003.⁷

⁷ Data were obtained from the Uniform Data Set (UDS) for community health centers. The five FQHCs that were included for the 2003 estimate on the total discounts provided to self-pay patients due to charity care were Panhandle Community Health Center, Good Neighbor Community Health Center, One World Community Health Center, Charles Drew Health Center, and People's Health Center. The 2003 bad debt expense data associated with self-pay patients were not available for the Good Neighbor Community Health Center.

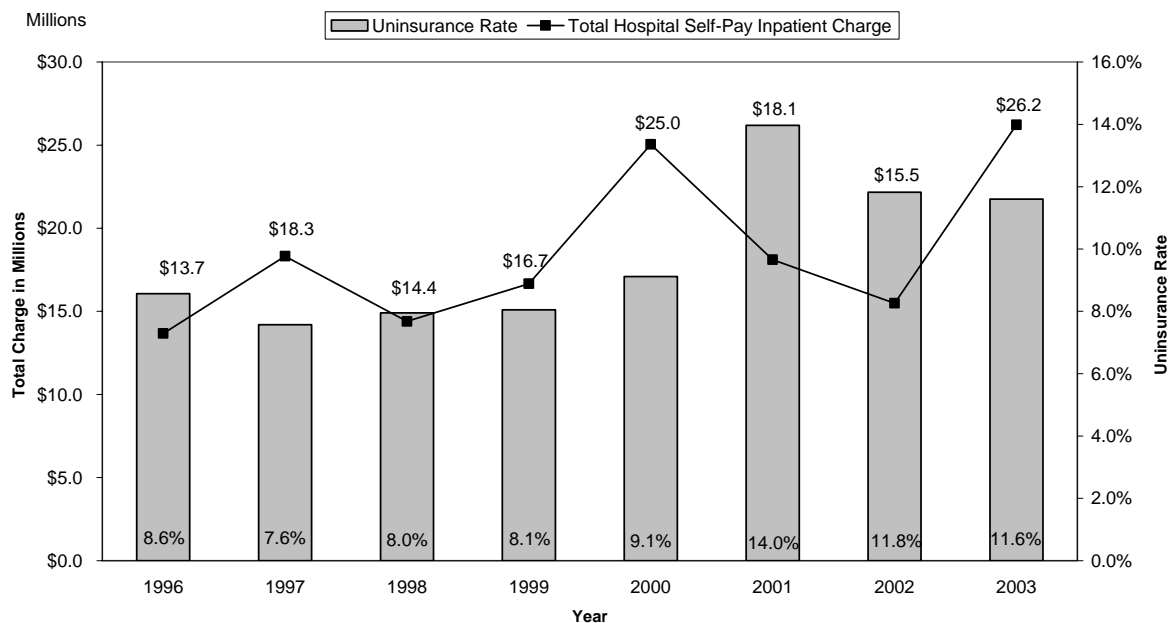
II. Expenditures of Hospital Inpatient Care for Self-Pay Patients

The availability of hospital inpatient discharge data allows us to further examine the time trend and geographic variation in hospital inpatient care utilization by self-pay patients, which is a potentially significant source for uncompensated health care. Using hospital charge data as a proxy for expenditure, we documented the state's hospital inpatient expenditures for self-pay patients in this section.

A. Statewide Expenditures for Hospital Inpatient Care of Self-Pay Patients

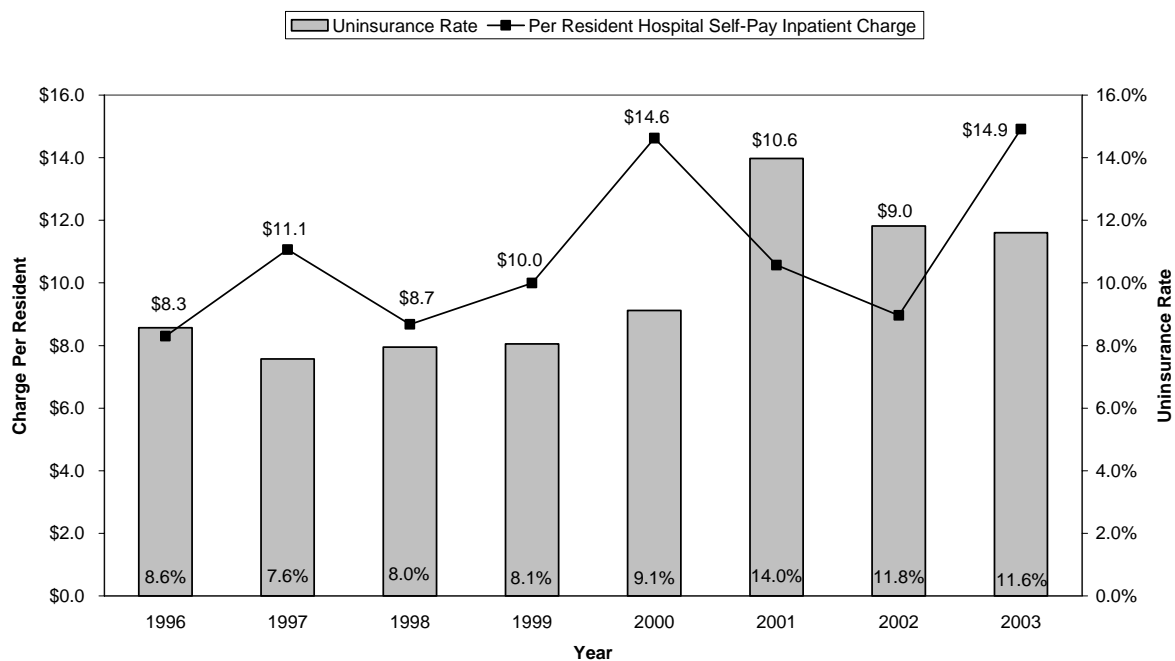
In Nebraska, the estimated total expenses for hospital inpatient care of self-pay patients increased by 92% from \$13.7 million in 1996 to \$26.2 million in 2003. During this 8-year period, there was a generally increasing trend in the expenses for hospital inpatient care of self-pay patients (Figure 7). During the same period of time, the uninsurance rate increased from 8.6% to 11.6% for Nebraskans. After accounting for the state's population, every resident in Nebraska on average bore a cost of \$8.3 due to hospitals' inpatient care for self-pay patients in 1996. This figure has generally increased since then, and reached a cost of almost \$15 per Nebraska resident in 2003. (Figure 8).

Figure 7. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in Nebraska, 1996 to 2003



Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

Figure 8. Estimated Per Resident Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in Nebraska, 1996-2003

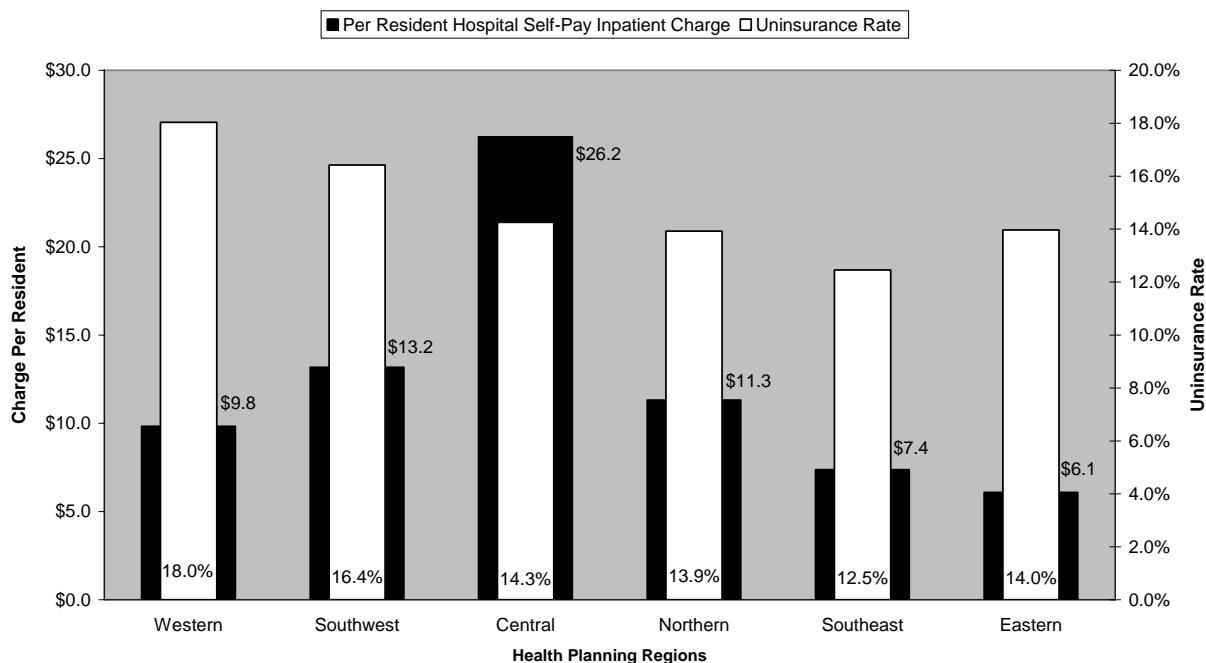


Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

B. Comparisons of Per Resident Expenditures for Hospital Inpatient Care of Self-Pay Patients among Health Planning Regions

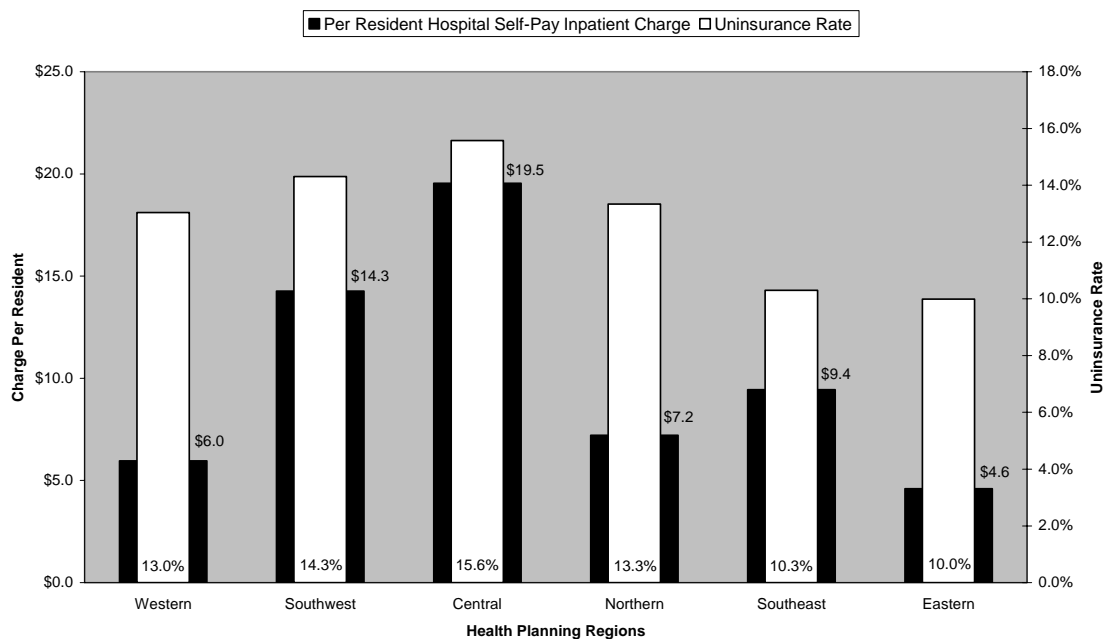
Residents in the Central Health Planning Region (i.e., Health Planning Region 3 or HPR 3) of Nebraska had the greatest estimated expenses of hospital self-pay inpatient care per resident in 2001-2003, as compared to their counterparts in the other five regions of the state (Figures 9, 10, and 11). Generally, residents in the three western regions (i.e., Western, Southwestern, and Central Health Planning Regions or HPRs 1, 2, and 3) had relatively greater estimated expenses for hospital self-pay inpatient care per resident during this three-year period, as compared to their counterparts in the three eastern regions (i.e., Northern, Southeastern, and Eastern Health Planning Regions or HPRs 4, 5, and 6). This is consistent with the finding that residents in the three western regions had a generally higher uninsurance rate than their counterparts in the three eastern regions. Nevertheless, residents in the Southeastern Health Planning Region (i.e., HPR 5) had the second greatest estimated expenses for hospital self-pay inpatient care per resident in 2003, which was an increase of 120% from 2002 (\$9.4 per resident) to 2003 (\$20.7 per resident).

Figure 9. Estimated Per Resident Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate by Health Planning Region in Nebraska, 2001



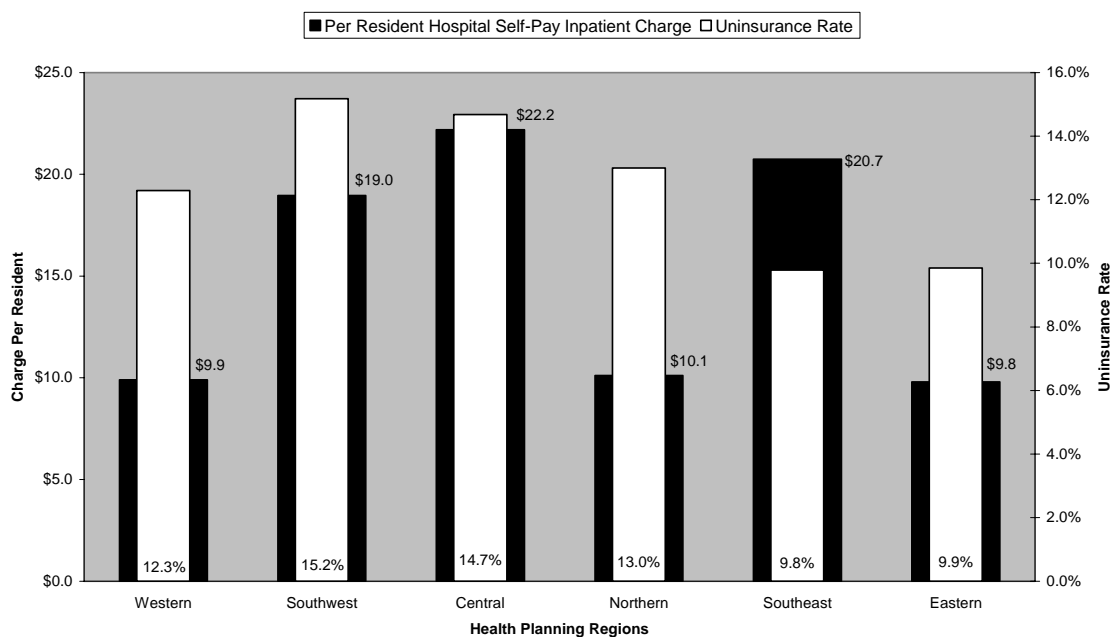
Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 2001, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 2001.

Figure 10. Estimated Per Resident Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate by Health Planning Region in Nebraska, 2002



Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 2002, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 2002.

Figure 11. Estimated Per Resident Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate by Health Planning Region in Nebraska, 2003



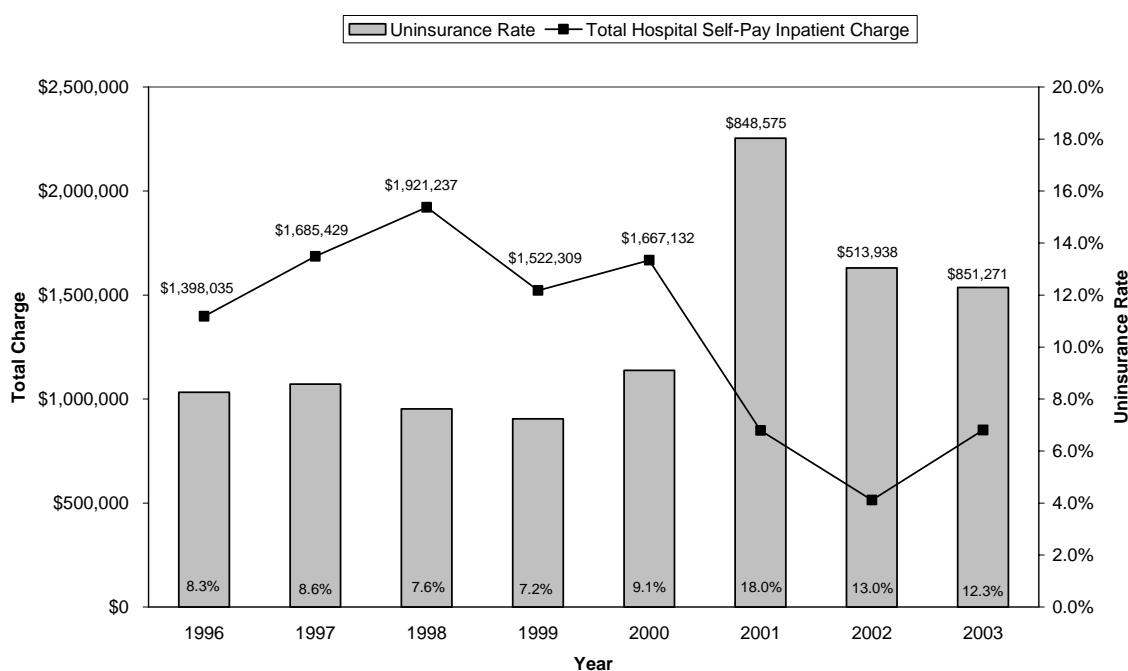
Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 2003.

C. Region-Wide Expenditures for Hospital Inpatient Care of Self-Pay Patients

Western Health Planning Region

The estimated total expenses for hospital self-pay inpatient care in the Western Health Planning Region (i.e., HPR 1) declined by 39% from \$1.4 million in 1996 to \$0.9 million in 2003. There was a generally decreasing trend in the estimated total expenses for hospital self-pay inpatient care in the Western Health Planning Region during this eight-year period, with two peak points (\$1.9 million in 1998 and \$1.7 million in 2000) in between (Figure 12).

Figure 12. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in the Western Health Planning Region of Nebraska, 1996 to 2003

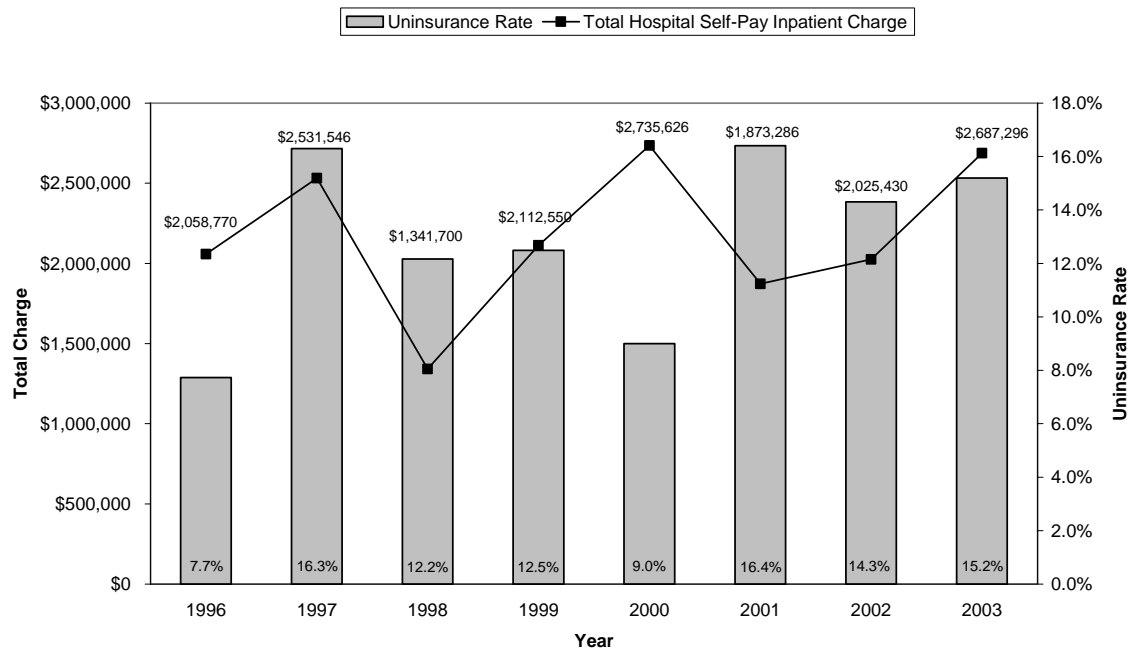


Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

Southwestern Health Planning Region

The estimated total expenses for hospital self-pay inpatient care in the Southwestern Health Planning Region (i.e., HPR 2) increased by 31% from \$2.1 million in 1996 to \$2.7 million in 2003. The trend in the estimated total expenses for hospital self-pay inpatient care in the Southwestern Health Planning Region fluctuated during this eight-year period, with two obvious peak points (\$2.5 million in 1997 and \$2.7 million in 2000) in between (Figure 13).

Figure 13. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in the Southwestern Health Planning Region of Nebraska, 1996 to 2003

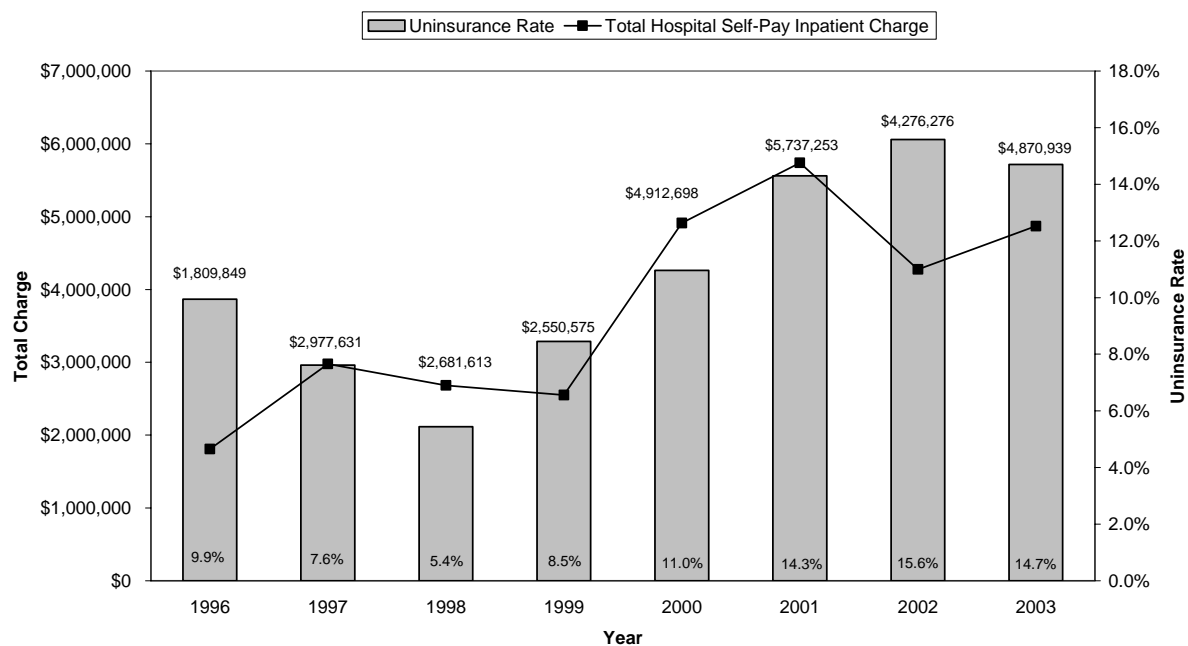


Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

Central Health Planning Region

The estimated total expenses for hospital self-pay inpatient care in the Central Health Planning Region (i.e., HPR 3) increased by 169% from \$1.8 million in 1996 to \$4.9 million in 2003. There was a generally increasing trend in the estimated total expenses for hospital self-pay inpatient care in the Central Health Planning Region during this eight-year period, with two peak points (\$3.0 million in 1997 and \$5.7 million in 2001) in between (Figure 14).

Figure 14. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in the Central Health Planning Region of Nebraska, 1996 to 2003

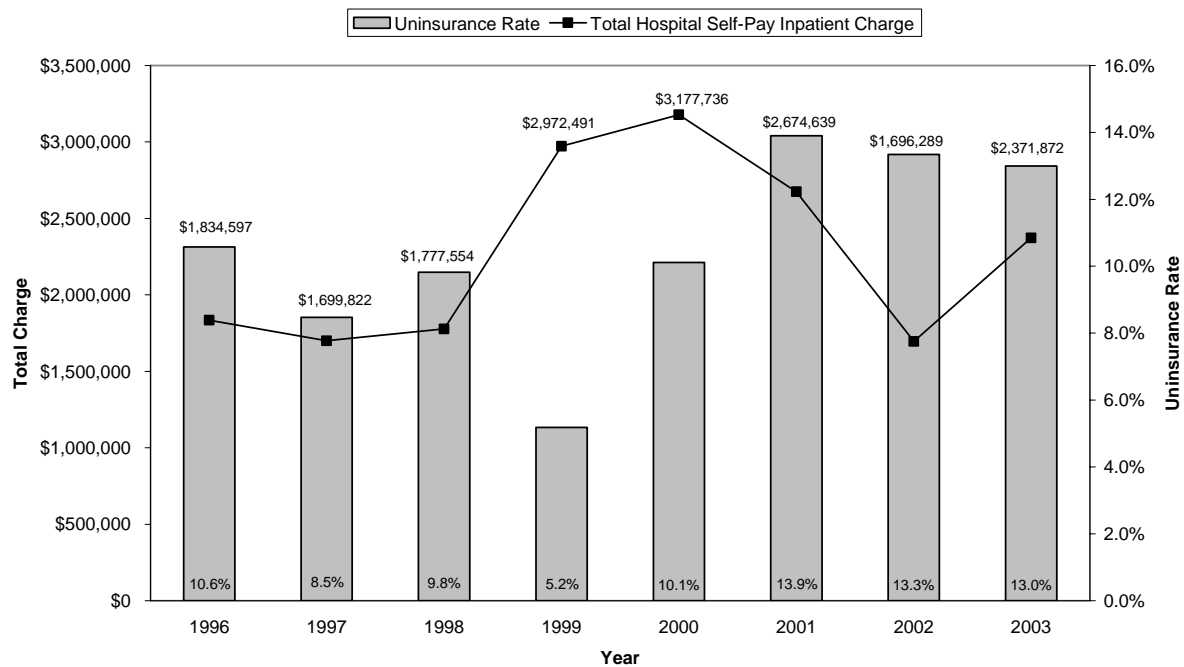


Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

Northern Health Planning Region

The estimated total expenses for hospital self-pay inpatient care in the Northern Health Planning Region (i.e., HPR 4) increased by 29% from \$1.8 million in 1996 to \$2.4 million in 2003. The trend in the estimated total expenses for hospital self-pay inpatient care in the Northern Health Planning Region fluctuated during this eight-year period, with one obvious peak point (\$3.2 million in 2000) in between (Figure 15).

Figure 15. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in the Northern Health Planning Region of Nebraska, 1996 to 2003

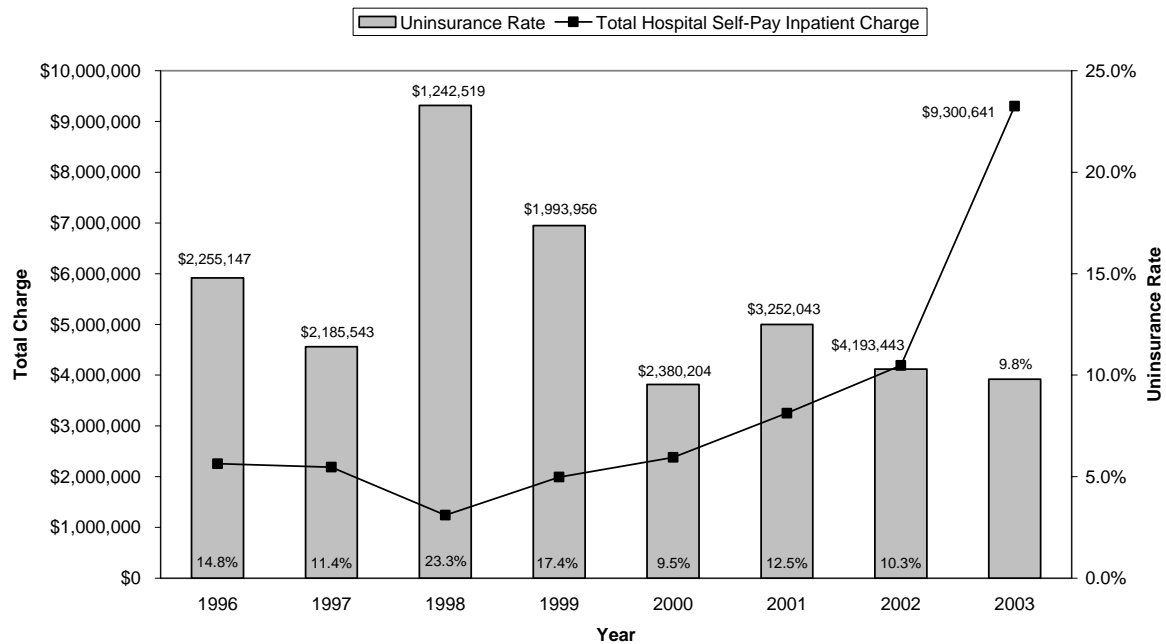


Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

Southeastern Health Planning Region

The estimated total expenses for hospital self-pay inpatient care in the Southeastern Health Planning Region (i.e., HPR 5) increased by 312% from \$2.3 million in 1996 to \$9.3 million in 2003. There was a steeply increasing trend in the estimated total expenses for hospital self-pay inpatient care in the Southeastern Health Planning Region during this eight-year period (Figure 16).

Figure 16. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in the Southeastern Health Planning Region of Nebraska, 1996 to 2003

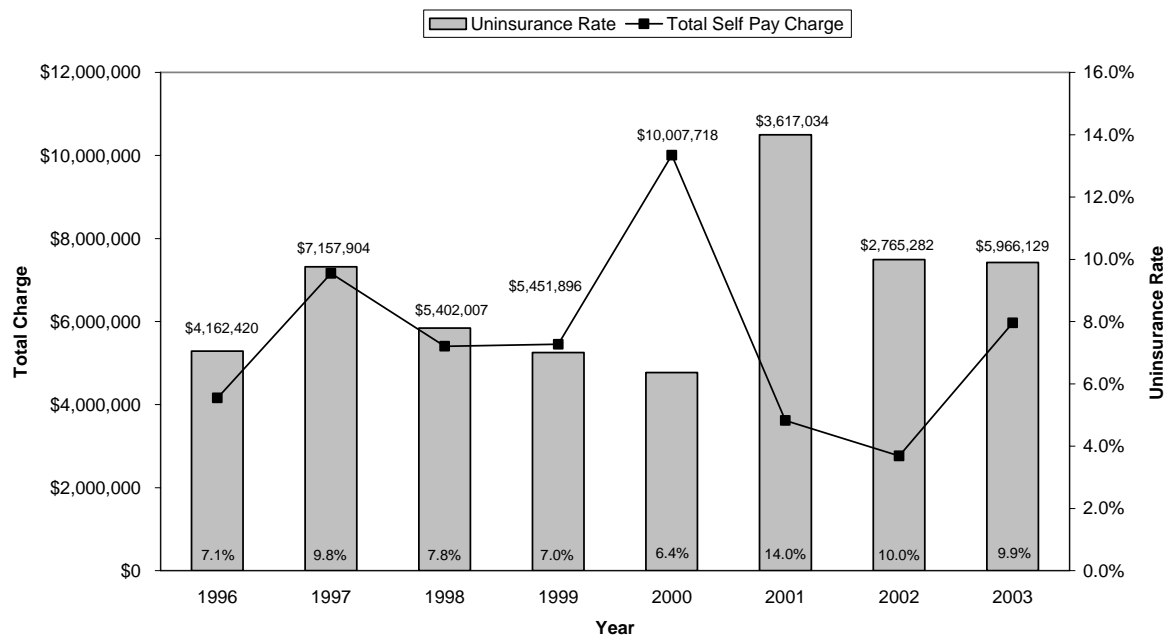


Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

Eastern Health Planning Region

The estimated total expenses for hospital self-pay inpatient care in the Eastern Health Planning Region (i.e., HPR 6) increased by 43% from \$4.2 million in 1996 to \$6.0 million in 2003. The trend in the estimated total expenses for hospital self-pay inpatient care in the Eastern Health Planning Region fluctuated during this eight-year period, with two peak points (\$7.2 million in 1997 and \$10 million in 2000) in between (Figure 17).

Figure 17. Estimated Total Charge for Hospital Self-Pay Inpatient Care, and Population Uninsurance Rate in the Eastern Health Planning Region of Nebraska, 1996 to 2003



Sources: Health Information Project, Nebraska Center for Rural Health Research; Hospital Inpatient Discharge Data 1996-2003, Nebraska Hospital Association; and Nebraska Behavioral Risk Factor Surveillance System for uninsurance data 1996-2003.

III. Determinants of Hospital Inpatient Expenditures for Self-Pay Patients

To better understand the potential reasons for the use of uncompensated health care, we used statistical modeling and a regression analysis approach to examine the determinants of hospital self-pay inpatient care utilization (see the Data Notes section for a detailed description of the methodology and data sources used for this analysis). Our particular variables of interest were economic and geographic factors.

Geographic Factors

The results from our regression analysis (Table 1) concur with the descriptive data shown in section II. The per resident expenditures for hospital inpatient care of self-pay patients in the western part of the state (i.e., Western, Southwestern, and Central Health Planning Regions) was statistically significantly higher than that in the eastern part of the state (i.e., Eastern, Southeastern, and Northern Health Planning Regions). In particular, using the Eastern Health Planning Region as the reference group, residents in the Western Health Planning Region had on average a statistically higher per resident charge by \$7.49 than did their counterparts residing in the Eastern Health Planning Region (p-value < 0.05). Similarly, residents in the Central Health Planning Region had on average a statistically higher per resident charge by \$7.53 than did their counterparts residing in the Eastern Health Planning Region (p-value < 0.05). The regression results show that residents living in the Southwestern Health Planning Region had on average the highest per resident charge—\$8.08 higher than that of their counterparts residing in the Eastern Health Planning Region (p-value < 0.05).

Time Trend

The regression results also confirmed the statewide time trend in the hospital inpatient charges for self-pay patients shown in Figures 7 and 8. The results show that Nebraskans incurred statistically higher hospital self-pay inpatient charges in both 1997 and 2000 relative to 1996 (i.e., a marginal increase of \$3.07 per resident in 1997 and a marginal increase of \$4.14 per resident in 2000). This finding is consistent with the pattern of time trend shown in Figures 7 and 8, where the two peak points occurred in 1997 and 2000.

Economic Determinants

Although the regression analysis showed that the population uninsurance rate was not statistically significant in explaining the county variation in per resident hospital self-pay inpatient charge, this result is under our expectation because the uninsurance data at the county level from the Behavioral Risk Factor Surveillance System may not be reliable due to small sample size. Nevertheless, the positive coefficient of the uninsurance variable is still consistent with the conventional wisdom that more uninsured people would lead to a greater magnitude of utilization of hospital care by self-pay patients. Moreover, the regression results on other economic factors provide some useful insight into the possible reasons for hospital inpatient utilization by self-pay or uninsured patients. In particular, when the percentage of county population who receive welfare assistance from the Temporary Assistance for Needy Families program (TANF) increases by 1%, the per-resident hospital self-pay inpatient charge shows a

statistically significant increase by \$0.06 (p-value < 0.01). In addition, when the county unemployment rate increases by 1%, the per-resident hospital self-pay inpatient charge shows a statistically significant increase by \$0.89 (p-value < 0.1). On the other hand, when the county per capita income increases by \$1,000, the per-resident hospital self-pay inpatient charge shows a statistically significant decrease by \$0.6 (p-value < 0.01). These results confirm that the population's economic conditions, as economic theory suggests, affect their health insurance status, thus influencing the magnitude of self-pay hospital care utilization, which constitutes a potential source for uncompensated care.

Table 1. Economic, Geographic, and Time-Related Determinants of Hospital Self-Pay Inpatient Expenditures in Nebraska, 1996-2003

Explanatory Variable	Coefficient	Standard Error
<i>Economic variable</i>		
Percentage of county population receiving TANF assistance	0.06***	0.02
County unemployment rate	0.89*	0.47
Per capita income†	-0.0006***	0.0002
County uninsurance rate	0.03	0.03
<i>Geographic variable</i> (Eastern as the reference)		
Western	7.49**	3.49
Southwestern	8.08**	3.45
Central	7.53**	3.60
Northern	1.56	3.25
Southeastern	0.17	3.33
<i>Time-related variable</i> (Year 1996 as the reference)		
Year 1997	3.07**	1.40
Year 1998	-0.70	1.07
Year 1999	1.16	1.29
Year 2000	4.14**	1.69
Year 2001	1.27	1.43
Year 2002	1.70	1.37
Year 2003	1.80	1.52

*significant at p<0.1

**significant at p<0.05

***significant at p<0.01

† Because county per capita income data are only available for years 1996-2002, the coefficient was obtained from another regression model that only used these seven years of data.

References

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Data Notes

1. The methodology of estimating state-wide hospital uncompensated care and Medicaid/Medicare payment shortfalls used in this report

The original uncompensated care and Medicaid/Medicare payment shortfall data used in this report were based on the responding hospitals in the Nebraska Hospital Association's (NHA) 2001-2003 Nebraska Hospitals Community Benefits Survey. In order to estimate the statewide hospital uncompensated care expenses and public program payment shortfalls, we extracted and used service volume data for all 94 Nebraska hospitals from the American Hospital Association's (AHA) annual survey data sets. We calculated the statewide estimates based on the following formula:

$$Es = (Er) \times (SVs/SVr)$$

In this formula,

Es is the estimated statewide hospital expenses of interest in a specific year (the expenses of interest could refer to traditional charity care, bad debt, or Medicaid/Medicare payment shortfalls).

Er is the total expenses of interest from all survey-responding hospitals in a specific year.

SVs is the state-wide hospital service volume in a specific year.

SVr is the total service volume for all survey-responding hospitals in a specific year.

(Er was based on the NHA's hospital survey; SVs and SVr were estimated using AHA data.)

Although in the report we only presented the statewide estimates on hospital uncompensated care expenses that were calculated using "adjusted patient day" data, we originally produced statewide estimates by also using other service volume or capacity data such as "number of beds," "total inpatient days," and "total outpatient visits." The rationale for using the statewide estimates based on "adjusted patient day" data in the report was that "adjusted patient day" may better measure the total service volume of a hospital by combining the utilization statistics of both inpatient and outpatient settings.⁸ As a reference, the statewide estimates based on other service volume or capacity data are also presented in the following three tables:

⁸ Based on the AHA's definition, adjusted patient day is calculated as "inpatient days + (inpatient days x (outpatient revenue/inpatient revenue))".

Data Note Table 1. Estimated **2003** Statewide Hospital Uncompensated Care Expenses and Medicaid/Medicare Payment Shortfalls Based on Various Service Volume or Capacity Variables

Service Volume or Capacity Variable (i.e., SV) used in the Estimation	Ratio of SVr to SVs	Estimated Statewide Hospital Traditional Charity Care Expenses	Estimated Statewide Hospital Bad Debt Expenses	Estimated Statewide Hospital Medicaid Payment Shortfalls	Estimated Statewide Hospital Medicare Payment Shortfalls
Beds	67.73%	\$98,307,517	\$173,181,625		
Inpatient Days	68.72%	\$96,899,654	\$170,701,489		
Outpatient Visits	66.93%	\$99,492,750	\$175,269,570		
Adjusted Patient Days	71.60%	\$92,998,922	\$163,829,838		
Medicaid Days	64.63%			\$127,669,053	
Medicare Days	85.77%				\$266,061,255

Note: The total expenses of interest from all survey-responding hospitals (i.e., Er) in 2003 were \$66,586,000 for traditional charity care, \$117,300,000 for bad debt, \$82,513,000 for Medicaid payment shortfalls, and \$228,212,000 for Medicare payment shortfalls. These numbers were based on a total of 49 hospitals that responded to NHA's 2003 Hospital Community Benefits Survey. See the complete list of the 49 responding hospitals in Appendix A.

Data Note Table 2. Estimated **2002** Statewide Hospital Uncompensated Care Expenses and Medicaid/Medicare Payment Shortfalls Based on Various Service Volume or Capacity Variables

Service Volume or Capacity Variable (i.e., SV) used in the Estimation	Ratio of SVr to SVs	Estimated Statewide Hospital Traditional Charity Care Expenses	Estimated Statewide Hospital Bad Debt Expenses	Estimated Statewide Hospital Medicaid Payment Shortfalls	Estimated Statewide Hospital Medicare Payment Shortfalls
Beds	66.20%	\$97,666,924	\$150,159,194		
Inpatient Days	68.66%	\$94,162,304	\$144,770,974		
Outpatient Visits	60.12%	\$107,532,663	\$165,327,394		
Adjusted Patient Days	70.68%	\$91,468,938	\$140,630,025		
Medicaid Days	71.67%			\$89,821,966	
Medicare Days	74.58%				\$267,285,401

Note: The total expenses of interest from all survey-responding hospitals (i.e., Er) in 2002 were \$64,652,000 for traditional charity care, \$99,400,000 for bad debt, \$64,373,000 for Medicaid payment shortfalls, and \$199,336,000 for Medicare payment shortfalls. These numbers were based on a total of 46 hospitals that responded to NHA's 2002 Hospital Community Benefits Survey. See the complete list of the 46 responding hospitals in Appendix A.

Data Note Table 3. Estimated **2001** Statewide Hospital Uncompensated Care Expenses and Medicaid/Medicare Payment Shortfalls Based on Various Service Volume or Capacity Variables

Service Volume or Capacity Variable (i.e., SV) used in the Estimation	Ratio of SVr to SVs	Estimated Statewide Hospital Traditional Charity Care Expenses	Estimated Statewide Hospital Medicaid Payment Shortfalls	Estimated Statewide Hospital Medicare Payment Shortfalls
Beds	51.62%	\$62,708,580		
Inpatient Days	52.29%	\$61,910,915		
Outpatient Visits	49.34%	\$65,610,374		
Adjusted Patient Days	50.60%	\$63,972,437		
Medicaid Days	53.53%		\$87,133,908	
Medicare Days	69.27%			\$211,284,044

Note: The total expenses of interest from all survey-responding hospitals (i.e., Er) in 2001 were \$32,372,373 for traditional charity care, \$46,640,640 for Medicaid payment shortfalls, and \$146,356,664 for Medicare payment shortfalls. Bad debt expense data were not available for 2001. These numbers were based on a total of 29 hospitals that responded to NHA's 2001 Hospital Community Benefits Survey. See the complete list of the 29 responding hospitals in Appendix A.

2. A description of the year-specific sample of responding hospitals on which the statewide estimates on uncompensated care expenses and Medicaid/Medicare payment shortfalls were calculated based

The Distribution of Responding Hospitals by Health Planning Region for Each Year

Region	2001	2002	2003
Western	2 (6.90%)	2 (4.35%)	3 (6.12%)
Southwestern	5 (17.24%)	6 (13.04%)	8 (16.33%)
Central	4 (13.79%)	10 (21.74%)	8 (16.33%)
Northern	7 (24.14%)	11 (23.91%)	12 (24.49%)
Southeastern	6 (20.69%)	10 (27.74%)	12 (24.49%)
Eastern	5 (17.24%)	7 (15.22%)	6 (12.24%)
Total	29 (100%)	46 (100%)	49 (100%)

The Distribution of Responding Hospitals in Terms of *Adjusted Patient Days* by Health Planning Region for Each Year

Region	2001	2002	2003
Western	60,639 (3.28%)	67,852 (2.85%)	107,595 (4.55%)
Southwestern	166,746 (9.03%)	182,596 (7.66%)	213,368 (9.03%)
Central	154,078 (8.34%)	297,504 (12.48%)	339,192 (14.35%)
Northern	214,621 (11.62%)	325,109 (13.64%)	340,873 (14.42%)
Southeastern	479,468 (25.97%)	577,385 (24.22%)	661,566 (27.99%)
Eastern	770,864 (41.75%)	933,058 (39.15%)	701,192 (29.66%)
Total	1,846,416 (100%)	2,383,504 (100%)	2,363,786 (100%)

3. A description of the year-specific sample of responding rural health clinics in the Nebraska Center for Rural Health Research's rural health clinic uncompensated care survey

The Distribution of Responding Rural Health Clinics by Health Planning Region for Each Year

Region	2001	2002	2003
Western	4 (11.43%)	4 (10.00%)	4 (10.00%)
Southwestern	6 (17.14%)	6 (15.00%)	6 (15.00%)
Central	4 (11.43%)	4 (10.00%)	4 (10.00%)
Northern	13 (37.14%)	17 (42.50%)	17 (42.50%)
Southeastern	8 (22.86%)	9 (22.50%)	9 (22.50%)
Eastern	0 (0%)	0 (0%)	0 (0%)
Total	35 (100%)	40 (100%)	40 (100%)

4. The methodology and data used for estimating the determinants of hospital self-pay inpatient care expenditures

We used a generalized estimating equation (GEE) approach to regress per resident hospital self-pay inpatient charge on the following explanatory variables: uninsurance rate, population demographic variables (e.g., % of elderly population, % of population aged 18-64), % of population under Temporary Assistance for Needy Families, hospital bed to population ratio, hospitalization rate, mortality rate, unemployment rate, per capita income, health planning region variables, and year variables. County-level data were available for each variable in each year from 1996 to 2003, with the exception that per capita income data from the same data source were only available for years 1996-2002. Therefore, we did another model estimation using only 1996-2002 data to examine the effect of per capita income on hospital self-pay inpatient charge.

Population demographic and mortality data came from the U.S. Census Bureau; hospital bed data came from AHA annual survey data sets; hospitalization data came from NHA's Hospital Inpatient Discharge data sets; TANF enrollment data came from Nebraska Health and Human Services System; unemployment data came from the Local Area Unemployment Statistics, Department of Labor, State of Nebraska; and per capita income data came from the US Bureau of Economic Analysis.

Appendices

Appendix A. The Lists of Responding Hospitals on Which the Statewide Estimates of Hospital Uncompensated Care Expenses and Medicaid/Medicare Payment Shortfalls Were Based

2003 Hospital List

Alegent Health Bergan Mercy Center
Alegent Health Immanuel Med Center
Antelope Memorial Hospital, Neligh
Avera St. Anthony's Hospital, O'Neill
Beatrice Community Hospital & Health Center, Beatrice
BryanLGH Health System, Lincoln
Butler County Health Care Center, David City
Chadron Community Hospital & Health Services, Chadron
Chase County Community Hospital, Imperial
Cherry County Hospital, Valentine
Children's Hospital, Omaha
Columbus Community Hospital, Columbus
Community Hospital, McCook
Community Memorial Hospital, Syracuse
Cozad Community Hospital, Cozad
Creighton University Med Center, Omaha
Crete Area Medical Center, Crete
Dundy County Health System, Benkelman
Faith Regional Health Services, Norfolk
Franklin County Memorial Hospital, Franklin
Fremont Area Medical Center, Fremont
Good Samaritan Health Systems, Kearney
Gordon Memorial Hospital, Gordon
Great Plains Regional Medical Center, North Platte
Jefferson Community Health Center, Fairbury
Kearney County Health Services, Minden
Litzenberg Memorial County Hospital, Central City
Madonna Rehabilitation Hospital, Lincoln
Mary Lanning Memorial Hospital, Hastings
Memorial Community Hospital Health System, Blair
Memorial Health Care Systems, Seward
Nebraska Medical Center, Omaha
Nebraska Methodist Hospital, Omaha
Nemaha County Hospital, Auburn
Osmond General Hospital, Osmond
Pender Community Hospital, Pender
Phelps Memorial Health Center, Holdrege
Providence Medical Center, Wayne
Regional West Medical Center, Scottsbluff

Rock County Hospital, Bassett
Saint Elizabeth Regional Medical Center, Lincoln
Saint Francis Medical Center, Grand Island
Saint Francis Memorial Hospital, West Point
Saunders County Health Service, Wahoo
Saint Mary's Hospital, Nebraska City
Tri-County Hospital, Lexington
Tri-Valley Health System, Cambridge
Valley County Hospital, Ord
West Holt Memorial Hospital, Atkinson

2002 Hospital List

Alegent Health Bergan Mercy Center
Alegent Health Immanuel Med Center
Antelope Memorial Hospital, Neligh
Avera St. Anthony's Hospital, O'Neill
Beatrice Community Hospital & Health Center, Beatrice
Brodstone Memorial Hospital, Superior
Brown County Hospital, Ainsworth
BryanLGH Health System, Lincoln
Chadron Community Hospital & Health Svs, Chadron
Cherry County Hospital, Valentine
Children's Hospital, Omaha
Columbus Community Hospital, Inc., Columbus
Community Hospital, McCook
Community Memorial Hospital, Syracuse
Cozad Community Hospital, Cozad
Creighton University Med Center, Omaha
Faith Regional Health Services, Norfolk
Franklin County Memorial Hospital, Franklin
Fremont Area Medical Center, Fremont
Good Samaritan Health Systems, Kearney
Great Plains Regional Medical Center, North Platte
Harlan County Health System, Alma
Howard County Community Hospital, Saint Paul
Jefferson Community Health Center, Fairbury
Litzenberg Memorial County Hospital, Central City
Madonna Rehabilitation Hospital, Lincoln
Mary Lanning Memorial Hospital, Hastings
Memorial Community Hospital Health System, Blair
Memorial Health Care Systems, Seward
Memorial Hospital, Aurora
Nebraska Medical Center, Omaha
Nebraska Methodist Hospital, Omaha
Nemaha County Hospital, Auburn

Osmond General Hospital, Osmond
Providence Medical Center, Wayne
Regional West Medical Center, Scottsbluff
Richard Young Center, Omaha
Rock County Hospital, Bassett
Saint Elizabeth Regional Medical Center, Lincoln
Saint Francis Medical Center, Grand Island
Saint Francis Memorial Hospital, West Point
St. Mary's Hospital, Nebraska City
Tri-County Area Hospital, Lexington
Tri-Valley Health System, Cambridge
Webster County Community Hospital, Red Cloud
York General Hospital, York

2001 Hospital List

Alegent Health Bergan Mercy Center
Alegent Health Immanuel Medical Center
Antelope Memorial Hospital, Neligh
Avera St. Anthony's Hospital, O'Neill
Brodstone Memorial Hospital, Superior
BryanLGH Health System, Lincoln
Chadron Community Hospital & Health Svs, Chadron
Cherry County Hospital, Valentine
Community Hospital, McCook
Creighton University Med Center, Omaha
Dundy County Health System, Benkelman
Faith Regional Health Services, Norfolk
Franklin County Memorial Hospital, Franklin
Fremont Area Medical Center, Fremont
Good Samaritan Health Systems, Kearney
Great Plains Regional Medical Center, North Platte
Madonna Rehabilitation Hospital, Lincoln
Memorial Health Care Systems, Seward
Nebraska Medical Center, Omaha
Nebraska Methodist Hospital, Omaha
Osmond General Hospital, Osmond
Providence Medical Center, Wayne
Regional West Medical Center, Scottsbluff
Richard Young Center, Omaha
Saint Elizabeth Regional Medical Center, Lincoln
Saint Francis Medical Center, Grand Island
St. Mary's Hospital, Nebraska City
Thayer County Health Services
Tri-County Area Hospital, Lexington

Appendix B. The Lists of Rural Health Clinics That Responded to the Uncompensated Care Surveys Conducted by the Nebraska Center for Rural Health Research

2003 RHC List

AMH Family Practice Medical Clinic
AMH – Clearwater Medical Clinic
AMH – Elgin Medical Clinic
AMH – Orchard Medical Clinic
AMH – Tilden Medical Clinic AMH Family Practice Clinic
Arapahoe Medical Clinic
Bancroft Medical Clinic
Beemer Medical Clinic
Community Physicians Clinic – Wymore
Costa Family Practice Clinic
Emerson Medical Clinic
FCMH – Campbell Medical Clinic
FCMH – Hildreth Medical Clinic
FCMH – Pool Medical Clinic
Friend Medical Center, P.C.
Garden County Health Services Clinic
Gordon Medical Clinic
Indianola Medical Clinic
Laurel Mercy Medical Clinic
Lone Tree Medical Associates, P.C.
Lone Tree Medical Associates, P.C.
Mitchell Medical Center
Park Street Medical Clinic
Pender Medical Clinic
Quality HealthCare Clinic at Benkelman
Quality Healthcare Services – Stratton Medical Clinic
Rock County Clinic
Rushville Medical Clinic
Saunders County Health Services – Coleman Clinic
Syracuse Medical Clinic
TCHS – Bruning Medical Clinic
TCHS – Chester Medical Clinic
TCHS – Davenport Medical Clinic
TCHS – Deshler Medical Clinic
Thayer County Health Services – Hebron Medical Clinic
Tilden Community Hospital Medical Clinic
Tri-Valley Health System – Cambridge Medical Clinic
Wakefield Mercy Medical Clinic
Wayne Mercy Medical Clinic
Wisner Mercy Medical Clinic

2002 RHC List

AMH Family Practice Medical Clinic
AMH – Clearwater Medical Clinic
AMH – Elgin Medical Clinic
AMH – Orchard Medical Clinic
AMH – Tilden Medical Clinic AMH Family Practice Clinic
Arapahoe Medical Clinic
Bancroft Medical Clinic
Beemer Medical Clinic
Community Physicians Clinic – Wymore
Costa Family Practice Clinic
Emerson Medical Clinic
FCMH – Campbell Medical Clinic
FCMH – Hildreth Medical Clinic
FCMH – Pool Medical Clinic
Friend Medical Center, P.C.
Garden County Health Services Clinic
Gordon Medical Clinic
Indianola Medical Clinic
Laurel Mercy Medical Clinic
Lone Tree Medical Associates, P.C.
Lone Tree Medical Associates, P.C.
Mitchell Medical Center
Park Street Medical Clinic
Pender Medical Clinic
Quality HealthCare Clinic at Benkelman
Quality Healthcare Services – Stratton Medical Clinic
Rock County Clinic
Rushville Medical Clinic
Saunders County Health Services – Coleman Clinic
Syracuse Medical Clinic
TCHS – Bruning Medical Clinic
TCHS – Chester Medical Clinic
TCHS – Davenport Medical Clinic
TCHS – Deshler Medical Clinic
Thayer County Health Services – Hebron Medical Clinic
Tilden Community Hospital Medical Clinic
Tri-Valley Health System – Cambridge Medical Clinic
Wakefield Mercy Medical Clinic
Wayne Mercy Medical Clinic
Wisner Mercy Medical Clinic

2001 RHC List

AMH Family Practice Medical Clinic
AMH – Clearwater Medical Clinic
AMH – Elgin Medical Clinic
AMH – Orchard Medical Clinic
AMH – Tilden Medical Clinic AMH Family Practice Clinic
Arapahoe Medical Clinic
Bancroft Medical Clinic
Beemer Medical Clinic
Community Physicians Clinic – Wymore
Costa Family Practice Clinic
Emerson Medical Clinic
FCMH – Campbell Medical Clinic
FCMH – Hildreth Medical Clinic
FCMH – Pool Medical Clinic
Friend Medical Center, P.C.
Garden County Health Services Clinic
Gordon Medical Clinic
Indianola Medical Clinic
Lone Tree Medical Associates, P.C.
Lone Tree Medical Associates, P.C.
Mitchell Medical Center
Park Street Medical Clinic
Pender Medical Clinic
Quality HealthCare Clinic at Benkelman
Quality Healthcare Services – Stratton Medical Clinic
Rock County Clinic
Rushville Medical Clinic
Saunders County Health Services – Coleman Clinic
TCHS – Bruning Medical Clinic
TCHS – Chester Medical Clinic
TCHS – Davenport Medical Clinic
TCHS – Deshler Medical Clinic
Thayer County Health Services – Hebron Medical Clinic
Tilden Community Hospital Medical Clinic
Tri-Valley Health System – Cambridge Medical Clinic

Appendix C. Survey Instrument for the RHC Uncompensated Care Survey Conducted by the Nebraska Center for Rural Health Research

Survey on Uncompensated Care of Nebraska Rural Health Clinics

Name of individual completing this questionnaire: _____

Clinic(s) Represented (Name, City, County):

Telephone: _____ E-mail: _____

Please fill in the table below with the total expenses associated with each of the following categories.

Expenses	2003	2002	2001
Traditional Charity Care Expenses **			
Bad Debt Write-off Expenses			
Total Clinic Expenses			

** Traditional charity care expenses do not include the shortfalls associated with insurance programs (e.g., Medicare, Medicaid).

1. Is your clinic hospital-based? Yes _____ No _____
If yes to question #1, please answer questions #2 and #3.

2. What is the name of the hospital on which your clinic(s) is(are) based?

3. Are your clinic's expenses of charity care and bad debt usually reported (included) within the financial statements of the hospital on which your clinic is based?
Yes _____ No _____